What is MIPS?

The Merit-based Incentive Payment System (MIPS) is one of the two tracks of the Medicare Quality Payment Program (QPP), which implements provisions of the Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA).

What must be submitted to successfully participate in MIPS?

To receive the highest score possible in the Quality Payment Program through MIPS, you must submit a full year of Quality measures, full year of Cost measures, 90 days of Improvement Activities measures and 90 days of Promoting Interoperability measures. Your MIPS payment adjustment in 2021 will be based on your performance for the following MIPS categories in 2019:
The reporting period for the Quality category is a 12-month period (January 1 through December 31, 2019). During this 12-month period, six measures must be reported and at least one outcome measure or another high-priority measure.

Clinicians choose measures on which they may report from a list. Some measures include:

- **Diagnostic Radiology Measures**
  - **Quality ID-145**: Radiology: exposure dose or time reported for procedures using fluoroscopy
  - **Quality ID-146**: Radiology: inappropriate use of “probably benign” assessment category in screening mammograms
  - **Quality ID-225**: Radiology: reminder system for screening mammograms
  - **Quality ID-195**: Radiology: stenosis measurement in carotid imaging reports
  - **Quality ID-361**: Optimizing patient exposure to ionizing radiation: reporting to a radiation dose index registry
  - **Quality ID-405**: Appropriate follow-up imaging for incidental abdominal lesions
  - **Quality ID-436**: Radiation consideration for adult computed tomography (CT): utilization of dose lowering techniques

- **Interventional Radiology Measures**
  - **Quality ID-076**: Prevention of central venous catheter (CVC)-related bloodstream infections
  - **Quality ID-145**: Radiology: exposure or dose time reported for procedures using fluoroscopy
  - **Quality ID-374**: Closing the referral loop: receipt of specialist report
  - **Quality ID-409**: Clinical outcome post endovascular stroke treatment
  - **Quality ID-413**: Door to puncture time for endovascular stroke treatment
  - **Quality ID-420**: Varicose vein treatment with saphenous ablation: outcome survey
  - **Quality ID-421**: Appropriate assessment of retrievable inferior vena cava (IVC) filters for removal
  - **Quality ID-437**: Rate of surgical conversion from lower extremity endovascular revascularization procedure
  - **Quality ID-465**: Uterine artery embolization technique: documentation of angiographic endpoints and interrogation of ovarian arteries

**Red: high priority measures**

Learn more at [qpp.cms.gov](http://qpp.cms.gov).
Improvement Activities - 15%

The reporting period for the Improvement Activities category is a 90-day to full-calendar-year period (January 1 through December 31, 2019).

Clinicians choose activities in which they may participate from a list. Some activities include:

- **IA_BE_6**: Collect and follow up on patient experience and satisfaction data
- **IA_BE_7**: Participate in a qualifying clinical data registry (QCDR)
- **IA_BE_16**: Use evidence-based decision aids to support shared decision-making
- **IA_CC_1**: Provide specialist reports back to the referring MIPS-eligible clinician or group
- **IA_CC_2**: Identify and communicate test results in a timely manner
- **IA_CC_4**: Participate in the Centers for Medicare and Medicaid Services (CMS) transforming clinical practice initiative
- **IA_PSPA_1**: Participate in an Agency for Healthcare Research and Quality (AHRQ) listed patient safety organization
- **IA_PSPA_14**: Participate in other quality improvement activities, such as Bridges to Excellence
- **IA_PSPA_16**: Use decision support and standard treatment protocols to manage workflow and meet patient needs
- **IA_PSPA_19**: Implement formal quality improvement methods, practice changes or other practice improvement processes
- **IA_EPA_1**: Provide 24/7 access to eligible clinicians or groups who have real-time access to a patient’s medical record

Learn more at [qpp.cms.gov](http://qpp.cms.gov).
Cost - 15%

Why report cost?
For 2019 Performance Year, the Cost category is 15 percent of the MIPS final score. Reporting on Cost measures in 2019 will help you understand the Cost category before the percentage increases in future performance years.

No cost category? What happens?
If you do not meet either of the case minimums for either measure of the Cost category, it will be reweighted to the Quality category. This will then result in the Quality category worth 60 percent of your MIPS final score instead of 45 percent.

How will you be scored?
• If only one measure can be scored, that score will be the performance score.
• There is no reporting required. CMS automatically calculates your score from claims submitted for payment.
• No score will be given to eligible clinicians who are not attributed any cost measures because of case minimum requirement or lack of benchmark.

Measures

Medicare spend per beneficiary (35 case minimum):
• Risk-adjusted Part A and B costs per inpatient admission
• Attributed based on service volume during hospitalization
• Includes the period immediately prior to, during and following a hospital stay ("episode")
• Includes all Part A and Part B claims

Total per capita cost (20 case minimum):
• Risk-adjusted per capita Part A and B costs
• Attributed based on primary care service volume
• Includes inpatient hospital, outpatient hospital, skilled nursing facility, home health, hospice, durable medical equipment, prosthetics, orthotics, supplies and Part B carrier claims

Episode-based measures:
• Electronic Outpatient Percutaneous Coronary Intervention (PCI)
• Knee arthroplasty
• Revascularization for lower extremity chronic critical limb ischemia
• Routine cataract removal with intraocular lens (IOL) implantation
• Screening/surveillance colonoscopy
• Intracranial hemorrhage or cerebral infarction
• Simple pneumonia with hospitalization
• ST-Elevation Myocardial Infarction (STEMI) with PCI

COST PERFORMANCE = \[
\frac{\text{Total points scored on each measure}}{\text{Total possible points available}}
\]

Learn more at qpp.cms.gov.
Promoting Interoperability (formerly known as Advancing Care Information) - 25%

The Promoting Interoperability (PI) performance category score is now performance-based (100 points with optional ten bonus points). The score is based on “objectives,” which have measures included in them.

Submit YES to:
- Prevention of information blocking attestation
- The Office of the National Coordinator for Health Information Technology (ONC) direct review attestation
- Security risk analysis completion:
  - No score attached
  - Must be during reporting calendar year reporting in
  - Required to receive PI score

Certified EHR Technology (CEHRT) requirements:
- 2015 edition
- Be in place for the 90-day reporting period chosen
- Be certified to 2015 edition by the last day of the selected reporting period

How is PI scored?

<table>
<thead>
<tr>
<th>Provider to patient exchange</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure Name</td>
<td>Points</td>
</tr>
<tr>
<td>Provider patient electronic access to their health information</td>
<td>40</td>
</tr>
</tbody>
</table>

| Public health and clinical data exchange (choose two – reported with a “Yes” or “No”) | Points |
| Measure Name | Points |
| Immunization registry reporting | 10 |
| Electronic case reporting | 10 |
| Public health registry reporting | 10 |
| Electronic reportable laboratory result reporting | 10 |
| Syndromic surveillance reporting | 10 |
| Clinical data registry reporting | 10 |

| Electronic prescribing (green measures are bonus measures) | Points |
| Measure Name | Points |
| E-Prescribing | 10 |
| Query of prescription drug monitoring drug program (PDMP) | 5 |
| Verify opioid treatment agreement | 5 |

| Health information exchange | Points |
| Measure Name | Points |
| Support electronic referral loops by sending health information | 20 |
| Support electronic referral loops by receiving and incorporating health information | 20 |

Learn more at qpp.cms.gov.